Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 2, 2005

1:30 PM

Room 3191

(Diane Van Maren)

Item	Department
4120	Emergency Medical Services Authority—*Selected Issues*
4260	Department of Health Services—*Selected Issues*
4440	Department of Mental Health—*Selected Issues*

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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I. 4120 Emergency Medical Services Authority

Background and Summary of Budget

The overall responsibilities and goals of the Emergency Medical Services Authority (EMS Authority) are to: (1) assess statewide needs, effectiveness, and coordination of emergency medical service systems; (2) review and approve local emergency medical service plans; (3) coordinate medical and hospital disaster preparedness and response; (4) establish standards for the education, training and licensing of specified emergency medical care personnel; (5) establish standards for designating and monitoring poison control centers; (6) license paramedics and conduct disciplinary investigations as necessary; (7) develop standards for pediatric first aid and CPR training programs for child care providers; and (8) develop standards for emergency medical dispatcher training for the "911" emergency telephone system.

Summary of Funding

The budget proposes total expenditures of $22 million ($10.8 million General Fund) for the EMS Authority. This reflects a net decrease of $1.1 million primarily due to a decrease in federal fund support.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Source				
Emergency Medical Services	$23,159	$22,036	($1,123)	-4.8
Unallocated Reduction	--	($12)		NA
Funding Source				
General Fund	$10,778	$10,777	1	--
Federal Funds	$3,808	$2,734	($1,074)	-28.2
Reimbursements	$7,097	$6,931	($166)	-2.3
Other Funds	$1,476	$1,594	$118	8.0
Total, Emergency Medical Services	$23,159	$22,036	($1,123)	-4.8

A. RECOMMENDED FOR VOTE ONLY—EMSA (*Two items*)

1. Child Care Provider Training

Issue: The Emergency Medical Services Authority (EMSA) is requesting an increase of $77,000 (Emergency Medical Services Training Program Fund) to fund a Staff Services Analyst position to staff the Preventive Health Training Program and conduct certain investigations of violations of statutes.

According to the EMSA, there are 1.5 staff presently employed to perform some of the required program functions, as noted below, but there is not sufficient staff to conduct the preventive health and safety training program that is also required, or to conduct needed investigations of violations of statutes.

Licensed childcare facilities are required by state statute to have at least one staff member on site, when children are present, that possesses a current pediatric first aid, CPR and preventive health and safety credential which includes training programs approved by the EMSA. These requirements are in recognition that children in preschool and before and after school care must have rapid access to emergency care as well as continual attention to illness and injury prevention.

Currently, a half-time Associate Governmental Program Analyst reviews the pediatric first aid, CPR and school bus driver first aid courses as well as provides technical assistance and complaint resolution. In addition, a support person processes course completion sticker orders, maintains a database, keeps the web page updated, process training program renewals and keeps accounting records for the fees that are paid into the EMS Training Program Fund.

However, staff is not available to complete the health and safety training programs in a timely manner or to conduct needed investigations of violations of statutes. Currently there is a backlog of one initial review of a training program and five reviews of training program renewals. In addition, there is a backlog of 25 cases needing investigation of violations of statutes and regulations pertaining to pediatric first aid, CPR and preventive health training programs.

The proposed activities of the requested position include the following:

- Review five new primary preventive health and safety training program submissions per year to determine compliance with regulations and correspond with training programs to submit missing items.
- Review training materials for about 28 existing primary preventive health and safety training programs per year that are renewing their approvals.
- Review courses provide by approved training programs and their affiliates to ensure that they are teaching the required topics in the time frames specified in regulations.
- Implement a quality improvement process which will include conducting site visits, developing a survey of students who have completed pediatric first aid, CPR and/or

preventive health and safety training curses to determine if the training programs taken meet the requirements of the regulations and to provide feedback to training programs on survey results, following up with training programs that have deficiencies and making recommendations for meeting minimum requirements as specified.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal. Fees collected from the training program approvals and course completion sticker sales fund the Child Care Unit and are deposited into the EMSA Training Program Fund

2. Emergency Medical Services Personnel Terrorism Response Training

Issue and Background: The Emergency Medical Services Authority (EMSA) is requesting expenditure authority of $270,000 (Reimbursements from the California Military Department through federal funds received by the Office of Homeland Security) *to continue* a one-year limited-term Associate Governmental Program Analyst and fund a contract to implement a terrorism response training evaluation project and establish training standards for Emergency Medical Services responders. The contract is for $120,000.

According to the EMSA, in the first year of this project, the following key tasks were completed:

- Established interim training standards for terrorism-response training for Emergency medical Technicians that are consistent with existing state and federal recommendations related to weapons of mass destruction and chemical, biological, radiological, nuclear and explosive terrorism-training for first responders;
- Completed an initial review of existing training programs;
- Established a list of approved programs; and
- Drafted proposed permanent guidelines for curriculum and course content of training courses.

The EMSA states that continuation of this project into 2005-06 will allow for the following:

- Completion of the guidelines and the formal adoption of those guidelines by the Commission on EMS;
- Development of an interactive, web-based, learning management system that will facilitate centralized record keeping of terrorism related courses and curricula taken by EMS personnel. It is planned to link the system to the record keeping systems of EMS' primary training partners: law, fire service, the Office of Emergency Services, DHS, and the California Military Department;
- Review of new training programs as they are established by private or pubic entities; and

- Completion of remedial and supplemental training plans for courses previously taken by personnel that did not include all regional topics.

The EMSA is working collaboratively with the California Military Department, the Office of the State Fire Marshal, the DHS and many others to identify and develop the training standards for multiple disciplines of first responders. Further they note that they are using an existing committee established by SB 1350 (McPherson), Statutes of 2002 to provide expert advice and to assist in developing the curriculum content.

The EMSA states that the resulting training standards can be used to prepare those personnel who provide emergency response to terrorism events in a manner that will protect the responders and victims.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

B. DISCUSSION ITEMS--EMSA

1. Medical Terrorism Threat Assessment

Issue: The budget proposes an increase of $311,000 (federal funds from the Office of Homeland Security) for the EMSA to (1) fund two positions, and (2) provide $20,000 for interdepartmental contracts (i.e., $12,000 Medical Director through UC Davis and $8,000 fiscal and personnel services from the DGS.). The two requested positions are a Staff Program Manager I and an Associate Governmental Program Analyst. The federal funds to be used for this purpose are provided by the Federal Office of Domestic Preparedness to the state Office of Homeland Security and then provided as reimbursement to the EMSA.

The funds will be used by the EMSA to provide intelligence analysis, assessment and operations response coordination for medical and health specific issues during normal business hours and during emergencies as part of the new Statewide Terrorism Threat Assessment Center (STTAC).

The EMSA medical intelligence staff will (1) query medical and health databases to provide real-time information on hospital and ambulance status statewide, (2) radio communications channel traffic and public health advisories/alerts, (3) have access to medical and public health experts to quickly secure technical assistance and expert advice to assist the STTAC in assessing implications of developing trends in emergency department visits, (4) monitor communicable disease outbreaks, (5) analyze information to identify credible threats, (6) recommend actions to take in the case of credible threats, and (7) coordinate a wide range of functions with law enforcement and other involved parties.

The EMSA notes that these activities will ensure that the medical and health community and state medical mutual aid system have ongoing access to critical information and analysis necessary for enhanced preparedness.

Background: The STTAC, under the direction of the state Office of Homeland Security and California Highway Patrol, operate from the Governor's Office of Emergency Services in Sacramento. STTAC provides analysis and assessment to law enforcement and other agency response partners of information leading to potential terrorist activities in California. Membership in what has traditionally been law enforcement-only field is being expanded to include other entities, such as local EMS agencies and the EMSA, to provide discipline specific medical and health, terrorism monitoring and analysis and operations response coordination.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the request.

Questions:

1. EMSA, Please describe the budget request and why the positions are needed.

2. Hospital Bioterrorism Response Preparedness—Finance Letter *(See Hand Out)*

Issues: The Governor's January budget proposed an expenditure of $6 million (federal bioterrorism funds) by the EMSA for activities related to the Hospital Bioterrorism Preparedness Program. Of this total amount, $817,000 was for state support and $5.2 million was for local assistance.

However, the Subcommittee is in receipt of a Finance Letter that now proposes to change the Governor's January budget to be as follows:

- Total expenditures of $6.2 million, for an increase of $200,000 over January;
- $2.9 million for state support, for an increase of $2.1 million over January;
- $3.3 million for local assistance, for a decrease of $1.9 million from January;

First, an increase of $200,000 has been received from the federal Health Resources and Services Administration (HRSA) to set up an Emergency System for the Advanced Registration of Volunteer Healthcare Personnel (ESAR-VHP) Program in California. This increase would provide a total of $1.2 million for this purpose (as shown in the table below).

The mission of this ESAR-VHP Program will be to develop Disaster Medical Personnel Guidelines to address (1) the identification and credentialing of volunteer medical staff in the event of a disaster, (2) liability and reciprocity issues, (3) investigation of statewide registries, and (4) integration of the Medical Reserve Corps Program. HRSA is requiring all states to develop an ESAR-VHP Program but there are numerous licensing, regulatory and legal barriers that must be resolved to create the system.

Second, the proposed $2.9 million for state support consists of several components as shown in the table below. As noted, about $1.9 million was shifted from local support to state support to provide for contract activities.

Table 1: Summary of State Support Expenditures ***(See Hand Out for description)***

Description	2005-06 Amount	Type of Expenditure
Six Positions (two-year limited-term)	$817,000	EMSA state support
Emergency Medical Services for Children	$150,000	Consulting & Professional--external
Austere Medical Care Guidelines	$100,000	Consulting & Professional--external
Hospital Surge Mgmt System	$100,000	Consulting & Professional--external
Emergency Sys for Advanced Registration of Volunteer Healthcare Personnel & Medical Reserve Corp	$1,200,000	Consulting & Professional—external, or interagency
Field Management Support System	$100,000	Consulting & Professional--external
Clinic Incident Command System	$338,000	Consulting & Professional--external
EMS Patient Tracking System	$100,000	Consulting & Professional--external
Total Amount for State Support	**$2,905,000**	

The budget proposes to provide $817,000 (federal bioterrorism funds) to continue 6, two-year limited-term positions to continue the development and implementation of a comprehensive, coordinated bioterrorism response system within California. These positions will be used to continue the following *key* activities:

- Develop statewide guidelines, protocols and plans for establishing field treatment sites (at the site of the emergency or at the hospital).
- Update and revise the Hospital Emergency Incident Command System, Version III (from 1998), and develop a training program with instructor certification associated with the activity.
- Investigate the feasibility of developing a clinic Incident Command System (ICS). The emergency management community uses such a system to manage response and recovery. However, clinics do not have a standardized ICS. The development of a Clinic ICS will enhance the interoperability with hospital and community emergency management operations.
- Develop strategies for the enhancement of trauma and burn surge capacity during an emergency, to prepare for a minimum of 50 burn or trauma patients per day during an emergency.
- Investigate and develop recommendations to address the mobilization of healthcare personnel during an emergency. This activity will include identification of regulatory barriers that inhibit the ability of licensed health care providers to participate in effective surge capacity response plans, and develop a standard definition and measurement of patient care personnel surge capacity.
- Develop a statewide emergency medical system mass casualty incident plan. Currently a plan for mass casualty events exists for the fire discipline but there is no standard, consistent plan for emergency medical services to manage mass casualty events.

The EMSA states that the $3.3 million for local assistance would be used as shown in the Table below.

Table 2: Summary of Local Assistance Expenditures

Program Area	**2005-06 Amount**	**Description**
Trauma & Burn	$500,000	Enhance trauma/burn capacity by purchasing equipment and supplies for regional caches throughout the state.
Poison Control	$300,000	Expand surveillance to detect chemical and other events
EMS for Children	$200,000	Two pilot projects to implement standards
Communications	$1.3 million	Expand communications systems and backup capabilities
Hospital Emergency Incident Command Sys	$500,000	Update materials for incident command program to include plan, training and process for certifying instructors
Ambulance Equipment	$500,000	Provide supplies and equipment caches placed in strategic locations across the state.
Total Local Assistance	**$3.3 million**	

Background Overall on HRSA Hospital Funds: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), among many other things, provided states increased federal support to address both local and state concerns regarding the threat of bioterrorism. The funds provided to California were obtained by submitting two comprehensive applications--one to federal HRSA and one to the federal CDC.

The federal HRSA funds are to be expended to develop and implement regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical service systems and other collaborating healthcare entities for responding to situations requiring mass immunization, treatment, isolation and quarantine in the event of infectious disease outbreaks or bioterrorism.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the request since it is consistent with the intent and purpose of the federal HRSA funds. No issues have been raised.

Questions:

1. EMSA, Please provide a brief description of the various projects, using Table 1 and Table 2, above, as a reference.
2. EMSA, Please describe the need for the positions.

II. Department of Mental Health

A. RECOMMENDED FOR VOTE ONLY—Mental Health

1. Transfer Department of Corrections GF Support to DMH for CDC Inmates

Issue and Background: The Subcommittee is in receipt of a Finance Letter which requests to transfer $61 million (General Fund) from the California Department of Corrections (CDC) to the DMH State Hospital appropriation to reflect a mutually agreed to decision by both departments.

Specifically, the DMH provides care and treatment to certain CDC inmates at Vacaville and Salinas Valley, as well as at the proposed 50-bed unit that will open at Coalinga State Hospital in September 2005. Presently the CDC reimburses the DMH for these services. Under this proposal, the DMH would receive the General Fund support directly.

The CDC budget presently reflects expenditures of $61 million for this population. As such this is the amount to be transferred to the DMH for this purpose. Additional adjustments may be needed at the May Revision when the State Hospital estimate is updated but this should represent only technical adjustments (such as for caseload).

The DMH notes that they will still continue their relationship with the CDC regarding requests for additional resources for CDC inmates and Memorandums of Understanding will be developed to identify each department's continued responsibility to identify inmates in need of mental health treatment and facilitate the transfers of those inmates between the CDC and the DMH.

Subcommittee Staff Comment and Recommendation: By transferring the General Fund support for CDC inmates in the DMH State Hospital and psychiatric programs from the CDC to the DMH, a number of administrative problems will be eliminated. Each year the DMH goes several months without receiving timely reimbursements for the services provided to CDC inmates. This has resulted in cash flow problems for the State Hospitals and has required the DMH to utilize loan authority that is provided for in Section 17601.10 of the Welfare and Institutions Code.

Subcommittee staff concurs with the request and has raised no issues with this proposal.

The proposed action conforms to Senate Subcommittee #5 on Corrections.

2. Projects for Assistance in Transition from Homelessness (PATH) Federal Grant

Issue: The Subcommittee is in receipt of a Finance Letter which requests an increase of $750,000 (federal PATH funds) based on the formula grant. These additional funds would be allocated to County Mental Health Plans (County Plans) as provided for in statute (See Hand Out package for distribution levels). This proposed increase would mean that a total of $7.4 million (federal funds) would be allocated in 2005-06.

Background: PATH provides funding to assist persons who are homeless (or at risk of becoming homeless) and have a mental illness. Counties receiving PATH funds must annually develop a service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. Allowable services include service coordination, alcohol and drug treatment, community mental health, housing services, supportive services in residential settings, and staff training. Presently 37 counties participate in PATH.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

3. Limited-Term Position for Disaster Preparedness

Issue: The budget proposes an increase of $94,000 (Reimbursements from federal bioterrorism funds from the DHS—federal CDC grant) to fund a Staff Mental Health Specialist position (two-year limited-term) to assist in implementing bioterrorism preparedness and capacity building.

The DMH is responsible for administering disaster response and recovery programs following natural disasters or human caused (terrorist) events that result in a Presidential disaster declaration. The DMH is the lead agency for mental health support in the event of a bioterrorism attach in California.

The DMH states that the position will conduct the following key activities: (1) Develop a bioterrorism plan for behavioral health hospital preparedness and training; (2) Work with local mental health disaster assistance staff and others to assess the need for mental health training competencies for health care professionals responding to bioterrorism or other public heath emergencies; (3) oversee the delivery of training and technical assistance to health care personnel on bioterrorism planning, preparedness, and mitigation issues; and (4) Participate in federal, state and local bioterrorism planning groups and advisory committees and assume the lead for mental health related responsibilities.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

4. Metropolitan State Hospital—Satellite Serving Kitchens

Issue: The budget proposes to shift $5 million from lease revenue bond funding to General Fund support to renovate all existing Satellite Kitchens and Dining Facilities at Metropolitan State Hospital. This is being proposed to meet requirements of DHS licensing and the "cook-chill" system. As noted below in the background, renovation of the six Satellite Kitchens must now use General Fund support.

The six Satellite Kitchens must be remodeled to include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles (asbestos abatement and related environmental aspects are a concern). According to the DMH, the scope of the remodel remains the same as contained in the Budget Act of 2003.

The DMH notes that this proposed solution would complete the project as originally submitted, while eliminating the problems identified in selling the lease revenue bonds, as noted below.

Background: The Budget Act of 2003 appropriated $18.7 million (Lease Revenue Bond Funds) to construct a new kitchen and remodel the six Satellite Kitchens at Metropolitan State Hospital. However, the DGS, DOF and DMH later recognized that selling bonds for the Satellite Kitchen component could not really be done. First, in order to sell the bonds, the entire building where each of the Satellite Kitchens are located would need to be used as collateral to secure the bond, rather than just the portion of the building planned for the Satellite Kitchen.

Second, one of the Satellite Kitchens is in a building that is rated at a seismic risk level 4 and other proposed Satellite Kitchens are in buildings which may need fire-life-safety improvements within the next 5 to 10 years, well before the term of the lease revenue bond would expire.

With these problems identified, it was determined to reduce the scope of the lease revenue bond project to just the new main kitchen building at Metropolitan and make the renovation of the Satellite Kitchens a General Fund project.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

5. Napa State Hospital—Expand Security Alert System

Issue and Background: The budget proposes an increase of $392,000 (General Fund) to expand the security alert system into the courtyards at Napa State Hospital. Currently there are six 24-hour patient (penal code-related) occupied buildings with adjoining court yards that do not have security alert systems. The security alert systems on the units are used any time staff needs assistance, and in the case of confrontation and/or behavioral problems with patients or the need for medical assistance

The funds would be used to install conduit, receivers, wiring and strobe lights, resulting in a complete and reliable alert system when staff needs assistance during emergency situations.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

6. Substance Abuse and Mental Health Services Administration (Grant)

Issue: The Subcommittee is in receipt of a Finance Letter that requests an increase of $303,000 (federal SAMHSA grant funds) to reflect a modest increase to the grant. These funds are proposed to be allocated by the DMH to the 58 counties receiving block grant dollars. The total amount of the federal SAMHSA grant funds will be about $55 million with this increase.

Historically, increases in federal SAMHSA grant funds have often been allocated based on the Cigarette and Tobacco Products Surtax formula to expand or enhance existing programs that serve adults with serious mental illness and children with serious emotional disturbance.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the Finance Letter. Additional federal grant funds have been provided and the allocation proposed by the DMH is consistent with past practices. The County Mental Health Plans can use these funds to provide additional services through contracts with local providers of services. No issues have been raised.

B. DISCUSSION ITEM—Department of Mental Health

1. DMH Request for Staff for Proposition 63 Implementation *(See Hand Outs)*

Issue: The Subcommittee is in receipt of a Finance Letter requesting an increase of $14.6 million (Mental Health Services Fund) to the DMH to fund 109 new positions to administer Proposition 63—the Mental Health Services Act (Act). Of these requested positions, 51 positions are in the process of being administratively established in the current-year. The Mental Health Services Act allows for the immediate expenditure of funds to implement the Act, including the hiring of staff. Up to 5 percent of the total revenues can be used for state support.

The request for the 109 positions is summarized in the Table below. As shown, the current-year established a total of 51 positions (20 permanent and 31 *three-year*, limited-term). The budget year then continues these current-year positions and adds additional positions for a total of 109 positions (55 permanent and 54 three-year, limited-term).

Table--Summary of DMH Proposal: Division and Description	**2004-05 February 1**	**2004-05 April 1**	**2005-06 (Permanent)**	**2005-06 (3-yr Term)**
I. Systems of Care Division				
Deputy Director's Office	6.0	1.0	3.0	2.0
Office of Multicultural Services		1.0	1.0	1.0
Adult & Older Adult Policy Section	1.0	2.0	4.0	4.0
Children & Family Policy Section	1.0	3.0	3.0	3.0
County Support & Administration			1.0	1.0
County Operations Sections	2.0	2.0	2.0	6.0
Prevention Policy Section		1.0	4.0	4.0
Performance Outcomes & Quality	3.0	1.0	3.0	2.0
Statistics and Data Section	2.0	1.0	2.0	2.0
Epidemiology, Allocation & Support		5.0	3.0	3.0
Human Resources, Education & Training	1.0		2.0	2.0
Subtotal	**16.0**	**17.0**	**28.0**	**30.0**
II. Division of Program Compliance				
Audit Section			3.0	5.0
Medi-Cal Oversight Section			3.0	3.0
Licensing & Certification		1.0	4.0	3.0
Subtotal		**1.0**	**10.0**	**11.0**
III. Administrative Services Division				
Financial Services	1.0	2.0	4.0	1.0
Human Resources	2.0	2.0	6.0	1.0
Information Technology Section		6.0	3.0	3.0
Legal Office		1.0	1.0	2.0
Subtotal	**3.0**	**11.0**	**14.0**	**7.0**
IV. CA Mental Health Planning Council			**2.0**	**2.0**
V. Mental Health Srv Oversight & Acct Commission	**1.0**	**2.0**	**1.0**	**4.0**
TOTALS	**20.0**	**31.0**	**55.0**	**54.0**

The DMH contends that the staff resources requested are needed and are commensurate with such a significant redesign of the mental health funding and service delivery system. They further state that as they complete more planning and more clearly understand the full impact of the Mental Health Services Act, they may request additional resources.

In addition to the position request, the Finance Letter proposes Budget Bill Language as shown below. This DOF recommended Budget Bill Language will enable both the DOF and the Legislature to more closely track state support expenditures. This language is particularly important since the Mental Health Services Act funds are continuously appropriated.

> 4444-001-3085 (DMH State Support)
>
> **"**Funds appropriated in this Item are in lieu of the amounts that otherwise would have been appropriated for administration pursuant to Section 5892 (d) of the Welfare and Institutions Code.
>
> Nothwithstanding any other provision of law, the Director of Finance may increase the funding provided in this Item to further the implementation of the Mental Health Services Act. Any increase would occur no sooner than 30-days after written notification has been provided to the Chairperson of the committee in each house of the Legislature that considers appropriations, the Chairpersons of the Committees, and appropriate Subcommittees, in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee identifying the need for such increase and the expenditure plan for the additional funds.**"**

Background—Summary of Key Aspects of Mental Health Services Act: A new Mental Health Services Oversight and Accountability Commission is to be established to implement this measure, and would have the role of reviewing and **approving** certain county expenditures authorized by the Act.

Appointments by the Governor are still pending, and as such, the Mental Health Services Oversight and Accountability Commission has not as yet been constituted. Both the Senate and Assembly have made their two appointments.

Each county is to submit for State review and approval a three-year plan for the delivery of mental health services within their jurisdiction. Counties are also required to provide annual updates and expenditure plans for the provision of mental health services.

Revenues generated by the Act are to be used to create new community mental health programs and to expand some existing programs. Funds cannot be used to supplant existing public mental health funding based upon a "maintenance-of-effort" provision defined in the Act.

Generally, the Act would provide funds to support the following programs/component areas:

- Children's System of Care: Expansion of system of care services for children who lack other public or private health coverage to pay for mental health treatment.
- Adult System of Care: Expansion of existing system of care services for adults with serious mental disorders or who are at serious risk of such disorders if they do not receive treatment.
- Prevention and Early Intervention: New county prevention and early intervention programs to get persons showing early signs of a mental illness into treatment before their illness becomes more severe.
- "Wraparound" Services for Families: A new program to provide state assistance to counties, where feasible, to establish wraparound services providing various types of medical and social services for families (such as counseling) where the children are at risk of being placed in group homes.
- "Innovation" Programs: New county programs to experiment with ways to improve access to mental health services, including for underserved groups, to improve program quality, or to promote interagency collaboration in the delivery of services to clients.
- Mental Health Workforce Education and Training: Stipends, loan forgiveness, scholarship programs, and other steps to (1) address existing shortages of mental health staffing in community programs, and (2) help provide additional staffing to carry out the program expansions in the Act.
- Capital Facilities and Technology: A new program to allocate funding to counties for technology improvements and capital facilities for the provision of mental health services.

The Act gives the Legislature limited authority to assist in its implementation. It specifies that it can be amended by the Legislature by a two-thirds vote so long as any amendments are "consistent with and further the intent" of the Act.

The Act also provides an exception to the two-thirds vote rule. Specifically, the Legislature can add provisions by majority vote to clarify procedures and terms of the measure.

Background—Summary of Proposition 63 Funding Provisions (See Hand Out): The Mental Health Services Act provides for a continuous appropriation of the funds. As such, the DMH is authorized to allocate funds for various purposes without appropriation by the Legislature in the annual Budget Act.

As shown in the DMH prepared hand out, the Mental Health Services Act allocates the revenues across the program areas, based upon a percentage of total revenues received for each fiscal year. The Table below provides a summary of the DMH estimate for three fiscal years.

Table—Summary of *Estimated* Funds (By Percentage Allocation as Contained in the Act)

Program Area	2004-05	2005-06	2006-07
Education & Training	$114.3 million	$68.3 million	$69 million
Capital Facilities & Technology	$114.3 million	$68.3 million	$69 million
Local Planning	$12.7 million	--	--
State Implementation/Admin	$12.7 million	$34.2 million	$34.5 million
Prevention Services	--	$136.6 million	$138 million
Community Services & Supports	--	$375.7 million	$379.5 million
Total Funding for the Act	**$254 million**	**$683 million**	**$690 million**
Prevention		$129.8 million	$131.1 million
Prevention Innovation		$6.8 million	$6.90 million
Subtotal Prevention		**$136.6 million**	**$138 million**
Community Services & Supports		$356.9 million	$360.5 million
Community Services Innovation		$18.8 million	$18.9 million
Subtotal Community Services		**$375.7 million**	**$379.5 million**

The revenues, which are deposited into the Mental Health Services Fund, are obtained from a personal income tax surcharge of 1 percent that applies to taxpayers with annual taxable incomes of more than $1 million. The State Controller transfers specified amounts of state funding each year on a monthly basis. The amounts deposited into the fund are to be adjusted later to reflect the revenues actually received from the tax surcharge.

Background—Summary of Existing Public Mental Health Funding: County Mental Health Plans are currently the primary providers of mental health services for persons who lack private coverage. Counties provide a range of services that are supported with a mix of state, local and federal funds.

County Realignment revenues are currently the largest revenue source for community mental health services in California. Counties use these revenues to provide necessary mental health care services to Medi-Cal recipients, as well as indigent individuals. It is estimated that almost $1.220 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. The second largest revenue source is federal Medicaid (Medi-Cal) dollars.

Specifically counties are responsible for: (1) All mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available; (2) The Medi-Cal Mental Health Managed Care Program; (3) The Early Periodic Screening Diagnosis and Testing (EPSDT) Program for adolescents; and (4) Mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families.

Legislative Analyst's Office Recommendation—Regarding State Staff Request: The LAO recommends for the Legislature to do the following:

- Reduce the requested 109 positions by 19 positions for a savings of $1.225 million (Mental Health Services Fund);
- Increase the DMH request for staffing of the Mental Health Services and Oversight Commission by three permanent positions and $266,000 (Mental Health Services Fund);
- Change the three-year limited-term positions to two-year limited-term positions as directed by existing state statue;
- Since 6 new audit positions are being added, assume an increase to the state's General Fund revenue of $1 million (General Fund) due to audit offsets;
- Adopt the Budget Bill Language, modified for the appropriation level, as proposed by the Administration; and
- Adopt placeholder trailer bill language directing the DMH to provide ongoing information to the Legislature regarding expenditure of the Mental Health Services Fund and implementation of the overall Act (See proposed trailer bill language below).

The LAO notes that the 109 requested positions represents a 60 percent increase in the DMH's overall headquarters' staffing. As such, it is unlikely that the department would accomplish the hiring by the end of 2005-06.

Further the LAO notes that (1) part of the new workload can be accommodated by current DMH staff instead of adding new staff, (2) a small part of the requested positions is for work unrelated to the new Act, and (3) insufficient workload justification has been provided to date for some of the positions.

The LAO's proposed placeholder trailer bill language is as follows:

> "At the time of the release of the January 10 budget plan and the May Revision, the Director of the Department of Mental Health shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure, for local assistance. This would include actual past-year expenditures, estimated current-year expenditures, and projected budget-year expenditures of local assistance funding.
>
> During each fiscal year, the Director of the Department of Mental Health shall submit to the fiscal committees of the Legislature, 30-days in advance, written notice of the intention to expend Proposition 63 local assistance funding in excess of the amounts

presented in its May Revision projection for that fiscal year. The written notice shall include information regarding the amount of the additional spending and its purpose."

Subcommittee Staff Comment and Recommendation: It is recommended to concur with the LAO recommendation. The number of positions proposed by the LAO makes sense, particularly given the number of positions that need to be hired within the year and the many, as yet unknown, aspects of what workload is going to be for this new Act.

Funds not spent on state administration are funds that can be used for local assistance. As such, a more moderate approach to state support is warranted at this time.

The LAO's recommendation to capture General Fund revenue from the new audit positions also makes sense. The Administration should have recognized the need and opportunity for General Fund savings to be achieved through this audit process.

Further, the Governor has not yet made his appointments to the Mental Health Services Oversight and Accountability Commission. These appointments need to be made in order for the Commission to be constituted and provide recommendations and approval for certain funding as required by the Act.

Questions:

1. DMH, When will the Mental Health Services Oversight and Accountability Commission be constituted?
2. DMH, Please provide a brief status update on Proposition 63 implementation.
3. DMH, Please provide a brief summary of the need for positions.
4. LAO, Please present your recommendation.

III. Department of Health Services

A. ITEMS RECOMMENDED FOR VOTE ONLY

1. Richmond Laboratory Phase III

Issue: The budget reflects a *net* savings of $1.640 million ($820,000 General Fund) for implementation of the "Phase III Office Building" of the Richmond Laboratory which is scheduled for completion by March 2005. This net savings reflects the interaction of savings from rent related to a building move and potential expenditures related to operating the new building.

The DHS states that occupancy of the new building will begin in late 2004-05 with the relocation of 170 staff from the DHS' old facility. This initial relocation is to be accomplished with existing funds. In 2005-06, the majority of the 625 staff will be moved from various leased space into the new building during the Summer of 2005.

Specifically, this budget-year proposal consists of a request to establish 6 new state positions and to fund certain operating equipment.

The proposed *net savings* result from the following adjustments:

- *Savings of $3.629 million* ($1.8 million General Fund, and $1.8 million in various special funds) from reduced rent due to the vacated lease from the old building.
- *An increase of $2 million* ($996,000 General Fund, and $979,000 special funds) for the following adjustments:
    - $457,000 ($229,000 General Fund, and $228,000 special funds) to support 6 new state positions. This includes the following personnel: (1) an Office Building Manager I, (2) a Staff Services Analyst, (3) three Stationary Engineers, and (4) an Office Technician. This also includes their operating expenses.
    - $77,000 one-time only for the purchase of equipment, including (1) electric carts (2 carts at $8,000 each), (2) various ladders, tools and tool carts ($5,000), (3) parking lot lighting repair service unit (1 at $50,000), and (4) electronic security cameras (3 at $2,000).
    - $188,000 for a moving contract.
    - $350,000 for utilities.
    - $917,000 for other contracts including landscaping, janitorial and security.

The DHS states that of the $2 million increase, $1.7 million will be on-going and $265,000 will be one-time only.

Additional Background Information: According to the DHS, the construction of the 200,000 square foot building is to be completed as of June 2005.

Presently there are 46.6 DHS maintenance staff that manage the Richmond Laboratory complex. The 6 new positions being requested would be an addition to this staff.

Subcommittee Staff Comment and Recommendation: The Subcommittee discussed this issue in its March 14 hearing and held the issue "open" pending receipt of additional information from the DHS. This information has been provided (that the savings would be ongoing). Therefore, it is recommended to approve as budgeted.

2. Health Services and Proposition 63—Request for One Staff

Issue: The Subcommittee is in receipt of a Finance Letter for implementation of Proposition 63—the Mental Health Services Act.

For the Department of Health Services, the Administration is requesting an increase of $105,000 ($52,000 Mental Health Services Fund and $53,000 federal funds) to support one new Staff Services Manager I position (*three-year*, limited-term).

This position would be used to build upon existing collaborative efforts with the Department of Mental Health to ensure that the state maximizes the availability of federal funds relating to the provision of mental health services.

The Finance Letter also proposes Budget Bill Language to account for the DHS state appropriation. This language is as follows:

> "Funds appropriated in this Item are in lieu of the amounts that otherwise would have been appropriated for administration pursuant to Section 5892 (d) of the Welfare and Institutions Code."

This language is proposed because the Mental Health Services Fund, established by Proposition 63, is a continuous appropriation and allows for a higher level of expenditure that what is being appropriated in the budget. This language will assist both the DOF and Legislature in tracking and accounting for state administrative expenditures.

Subcommittee Staff Comment and Recommendation: It is recommended to approve this request but **to utilize a two-year limited-term appointment** in lieu of three years.

This recommendation is consistent with the Legislative Analyst's Office recommendation regarding the overall Proposition 63 positions.

B ITEMS FOR DISCUSSION

1. New Born Screening Program Adjustments *("Open" issue)*

Issue: SB 142 (Alpert), Statutes of 2004, expanded the existing Newborn Screening Program from 39 conditions to 76 conditions through the use of Tandem Mass Spectrometry. This expansion is the product which resulted from a Pilot Project (AB 2427, Kuehl, Statutes of 2000) which operated from January 2002 through June 2003. The pilot ended when one-time funding from the Genetic Disease Testing Fund was expended.

The DHS was authorized to spend $2.7 million (Genetic Disease Testing Fund) in the current-year for the expansion of the Newborn Screening Program.

For the budget year, the DHS is requesting an increase of $15 million (Genetic Disease Testing Fund) to (1) support three new positions, and (2) purchase $14.8 million in equipment and related services, including Tandem Mass Spectrometry equipment and software, laboratory services, and information processing system modifications.

The three requested positions include one Public Health Chemist, one Research Scientist IV, and one Staff Services Analyst.

The enabling statute provided the DHS with authority to increase fees for this program, if required for the expansion effort. As such, the DHS is proceeding with emergency regulation authority to increase the fee from $60 to a total of $78, effective January 1, 2005.

According to statute as contained in SB 142 (Alpert), Statutes of 2004, the expanded program is to be up and operational by August 1, 2005.

Previous Subcommittee #3 Hearing and DHS Response to Questions: In the March 14th hearing, the Subcommittee requested additional information regarding fees and the notification process used under the program when there is a positive result in the screen.

- *DHS Response to Fees:* The enabling legislation (SB 142, Statutes of 2004) mandated that the Newborn Screening Program be fully supported from fees collected and authorized the DHS to charge a fee for tests, or activities, performed for the proposed expansion. Activities include the start-up costs associated with implementing statewide expanded screening, which costs must be paid in advance of actual screening activities. These start-up costs include equipment, reagents for development of clinical parameters to ensure effective identification of affected infants, training contractors, the purchase of blood collection forms and various other details.

The additional $18 per test in fees collected under the Newborn Screening Program are to cover the costs of all program activities, including startup costs, and are not tied directly to the number of tests performed, nor to the date the actual expanded screening begins. In order to implement expanded screening by the statutory deadline of August 2005, the DHS faced the necessity of raising the fees prior to implementation in order to adequately fund the myriad start up costs associated with the expanded newborn screening. All the fees collected are spent for services in support of newborns and their families.

The Administration states there are many instances where fees have been raised before services have begun. For example, developers can be charged fees today for services which will be provided at a later time. This includes fees for transit, sewer, park and lighting services which will be provided at a later date. The DHS states that the relationship between these examples and the expanded Newborn Screening Program is that all take time to develop and implement and there are expenses associated with these activities.

- ***DHS Response to Processing of Positive Results:*** When a baby has a positive screen, the testing laboratory contacts the appropriate follow-up center and informs the case coordinator. The case coordinator then contacts the physician who in turn contacts the family directly. The case coordinator follows up with a letter to the physician confirming the discussion and another letter is sent to the family. The letter to the family outlines the next steps.

  The case coordinator tracks the baby, ensuring any follow up tests are performed, and continues to follow the case until evidence of a proper referral and treatment is received.

Background—Newborn Screening Program: The Newborn Screening Program screens about 525,000 infants, or 99 percent of the annual births, in about 325 maternity hospitals. Newborns are screened for a series of heritable preventable metabolic disorders. At the time of birth, the heel of the infant is pricked and a drop of blood tested for different disorders. Birth defects often have no immediate visible effects on a baby but unless detected and treated early, can cause physical problems, mental retardation, and death.

When test results are abnormal, early diagnosis and proper treatment can make the difference between lifelong impairment and healthy development. Further, significant cost savings can be achieved through early detection and in some cases, simple dietary treatment of some disorder. Cost benefit analyses have found that expanded newborn screening produces significant net benefits. The DHS estimates that for every dollar spent on expanded screening, two dollars and fifty-nine cents ($2.59) is saved in average lifetime medical costs alone.

All screening is fee supported and is voluntary. Fees are collected from individuals, their health insurance, hospitals, birthing centers and the Medi-Cal Program. All fee collections are deposited in the Genetic Disease Testing Fund.

Subcommittee Staff Comment and Recommendation: The proposal is consistent with the enacted legislation. It is recommended to approve as budgeted.

Questions:

1. DHS, Please provide an update on the *key* components of the Newborn Screening Program expansion that have been completed and what is pending.
2. DHS, Please briefly explain the budget proposal.

2. Medi-Cal Provider Enrollment *(See Hand Out)*

Issue: The DHS is seeking (1) an increase of $1.7 million ($414,000 General Fund and $1.2 million federal funds) to fund 13 new Associate Governmental Program Analyst positions and an information technology project, *and* (2) Budget Bill Language regarding information technology projects.

First, the DHS proposes to hire 13 new Associate Governmental Program Analyst positions for *three-year* limited-term appointments. The purpose of these positions is to reduce the existing provider enrollment **backlog from 6 months to 5 months**.

Second, the DHS proposes to use $500,000 (total funds) in one-time only funding to develop a "front-end" application process for the submission of physician applications. This electronic application process will ensure that all required fields are completed online prior to submission to the DHS. The DHS states there is a 40 percent error rate on the part of physicians submitting their provider applications.

Third, since *no* Feasibility Study Report (FSR) has been completed by the DHS for this proposed information technology project, the DOF is proposing Budget Bill Language. Specifically, this Budget Bill Language says the following:

> "Of the funds appropriated for new information technology projects, including but not limited to the provider enrollment automation project, no funds may be expended prior to approval of feasibility study reports by the Director of Finance.

The DHS presently has about **120 positions** who conduct enrollment and re-enrollment efforts within the DHS. This includes staff who: (1) Process provider applications and return calls; (2) Perform secondary reviews on applications; (3) Review legislation; (4) draft regulations; (5) draft policy; (6) work on correspondence; (7) perform data entry in to the Provider Master File; (8) re-enroll providers; and (9) process mail and conduct related administrative work.

According to the DHS there are currently about 140,000 Medi-Cal providers who serve the medical needs of Medi-Cal enrollees throughout California. The DHS states that it receives about 36,000 applications (3,000 per month), along with thousands of miscellaneous documents that require that require research and clerical support. These applications represent submissions from more than 78 provider types, along with applications for re-enrollment. However it should be noted that some of these applications are submitted only due to a change in address or other related administrative reasons.

The DHS states that it can take from one to five hours to adequately review an application. On average, the DHS can process 2,600 applications per month. This leaves on average about 400 pending applications each month, adding to the inventory.

The DHS states that prior to an application being finalized, it must be reviewed by at least *four* different staff as it goes through the checks and balances necessary to process the application, input the provider information into the Provider Master File system, and issue a Medi-Cal billing number.

Background—Medi-Cal Provider Enrollment (See Hand Out): The DHS is required by statute to process Medi-Cal provider enrollment within 180-days (about 6 months), except for (1) those providers that request and are approved for "preferred provider" status within 90-days, or (2) applications referred to the DHS Audits and Investigations Branch for secondary review. Providers not enrolled within their respective timeframes are deemed "forced provisional" and receive a Medi-Cal billing number without a thorough review or background check.

It should be noted that the DHS only rejects about one to two percent of the applications. Therefore, over 98 percent of the applicants are approved to receive a Medi-Cal provider number.

Pending Legislation to Simplify Medi-Cal Provider Enrollment: There are several legislative proposals which are proceeding through the policy committee process which would revamp and simplify the provider enrollment process.

For example, Senate Bill 770 (Romero), as amended on March 30, 2005, would provide that a physician enrolled and in good standing in the Medi-Cal Program who is changing locations within the same county is eligible to continue enrollment at the new location by filing a change of location form, in lieu of submitting a complete application package.

Presently, a full application must be submitted and approved by the DHS for something so straightforward.

Legislative Analyst's Office Comment and Recommendation: The LAO recommends the following:

- Deny all of the requested 13 additional positions for a savings of $1.154 million ($289,000 General Fund);
- Approve the $500,000 ($125,000 General Fund) for the "front-end" information technology project (internet application for submission of the provider application) as proposed and
- Approve Budget Bill Language, as modified by Subcommittee staff, to require approval of a Feasibility Study Report. (See below).

The LAO believes the front-end, internet application to streamline the provider enrollment process would significantly reduce the number of errors currently found in the provider applications, and thereby, reduce the time the DHS spends processing applications. The LAO also believes that the DHS can redirect some existing staff within the Medi-Cal Provider Enrollment Branch and utilize this staff more effectively.

For example, following an initial staff analysis and recommendation for every provider application, a different staff member currently performs a secondary analytical review. The LAO suggests that performing such secondary review on a sample basis would be adequate instead of performing a secondary review on all of the applications.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO recommendation to deny the 13 requested positions and to approve the automating the Medi-Cal enrollment application form. Automation of the Medi-Cal enrollment application form, as well as "redesigning" their Medi-Cal provider enrollment process should result in a more efficient and effective system.

With respect to the Budget Bill Language, it is recommended to adopt the language with a modification as shown below:

> "Of the funds appropriated for new information technology projects, including but not limited to the provider enrollment automation project, no funds may be expended prior to approval of feasibility study reports by the Director of Finance. The Department of Health Services shall provide notification to the fiscal committees of both houses of the Legislature within 30 days of the approval by the Director of Finance, along with a copy of the approved feasibility study report as consistent with the Director of Finance's changes.

Questions:

1. DHS, Please briefly describe the existing Medi-Cal Provider Enrollment process.
2. DHS, Please explain the budget proposal, including both the need for the positions and the information technology project.
3. DHS, What work has been done to date regarding the development of the Feasibility Study Report (FSR)?

3. Hospital Financing Waiver—Status Update from Administration

Issue: The Administration has been working since June, 2004 to craft a new Hospital Financing Waiver with the federal CMS. California's existing Waiver will expire as of June 30, 2005. The Subcommittee has discussed this issue in three prior Subcommittee hearings (February 17th, March 2nd, and March 23rd). The Administration continues to assume no additional General Fund support for hospitals, other than what is presently provided. There are still many moving parts to the Administration's proposal.

Update From the DHS: Based on information obtained as of April 25th, the following tables outline the **(1)** amount of federal funds the Governor is requesting from the federal CMS, **(2)** potential sources of "certified public expenditures" (CPE), and **(3)** other programs that can be used to draw done federal funds.

As noted in **Table 1,** below, the "maximum" amount the Administration is seeking is $671 million. This consists of three core components.

The first component—the Disproportionate Share Hospital (DSH) "swap"—consists of shifting private hospitals out of the DSH funding arrangement and instead, using "regular" Medi-Cal funds (i.e., General Fund and federal fund match) to support these hospitals. The General Fund match for this to occur would come from the public hospitals. According to the DHS, this "swap" would enable the state to obtain about $226 million more in additional federal funds than our existing DSH allotment.

This swap would mean that the public hospitals would be reliant on "certified public expenditures" (CPEs), limited Intergovernmental Transfers (IGTs) and federal funds for their primary support. DSH funding (i.e., SB 855) would only be used for the public hospitals.

The second component is the $180 million which is presently part of California's existing federal Waiver. This $180 million represents the five-year average of funds provided for indigent care in Los Angeles County through the expiring Los Angeles County Waiver (expires as of June 30, 2005). This component is in question with the federal government even though it is clearly a critical funding piece for California. The DHS states that these funds, if approved as part of the new Waiver, would be used to support hospitals statewide and not only those located in Los Angeles County.

The third component is the "growth factor" which assumes an eight to nine percent escalator of certain baseline funds. This growth factor is based upon the federal government's assumptions and could conceivably change in future years.

Other aspects regarding the proposed five-year federal Waiver remain the same at this time, including provisions regarding: (1) Federal budget neutrality (i.e., a federal funding cap or limit); (2) The de-linking of Medi-Cal Managed Care Program inpatient hospital day payments from the receipt of supplemental federal funds; and (3) Continuation of the hospital contracting program (i.e., Selective Provider Contracting Program).

Table 1—Governor's Federal Fund Request for California to Federal CMS for 2005-06

Description of Component	Potential Federal Fund Amount	Subcommittee Staff Comment
Move private hospitals from DSH to regular Medi-Cal (i.e., DSH "swap") and eliminate the state's existing $85 million "administrative fee".	$226 million (solid)	This proposal "frees-up" federal funds and is something that we could be doing now. This piece has not changed since February and is *not* in question with the federal CMS.
5-year average of funds provided for indigent care under Los Angeles Waiver (Los Angeles Waiver expires 6/30/05)	$180 million (unknown)	Federal approval of this component is unknown. Federal OMB did not previously capture these costs in their federal budget projections.
Waiver Growth Funding	$265 million (fluctuates and contingent on base level funding)	Certain components of this Waiver would be increased at a rate of 8 to 9 percent annually.
Maximum Amount Available	**$671 million**	Still pending federal approval
Amount without the $180 million	**$491 million**	

Table 2 below is the Administration's illustration of potential sources for obtaining necessary "certified public expenditures" that will be needed to draw down the federal match. Public hospitals and UC hospitals would "certify" they have expended public funds to provide services to indigent individuals and Medi-Cal enrollees. The CPEs would be used within the "Safety Net Pool" to draw down supplemental federal funds. In addition, a limited-Intergovernmental Transfer (IGT) mechanism could be used for those public hospitals above 100 percent of uncompensated costs up to 175 percent of such costs.

Table 2—Potential Sources of "Certified Public Expenditures" to Match Federal Funds

Description of Component	Amount Available for Match	Subcommittee Staff Comment
A. Hospital-Based CPEs		
University of CA System Hospitals	*minus* $15 million	CPE is needed here
Los Angeles County Hospitals	$72 million	
Other large public Hospitals	$126 million	
Private and District Hospitals	$67 million	
Amount Available for Match--Hospitals	**$251 million**	
B. Public Clinic CPEs		
University of CA System Clinics	*Pending*	
Los Angeles County Clinics	$107 million	
Other Public Clinics	$14 million	Estimate of clinics associated with large county hospitals other than Los Angeles.
Amount Available for Match--Clinics	**$121 million**	
TOTAL Amount Available for Match	**$372 million**	
Range of *Shortfall* for Federal Match (i.e., additional "CPE" needed)	**$119 million to $299 million**	Other sources of "CPE" are needed.

It should be noted that based on information obtained from the DHS, there are at least five county hospitals that do not have enough "CPE" in order to draw down their existing amount of federal funds that they presently receive through the existing IGT process.

Therefore, the complexities of the CPE process will need to include how "available or excess" CPE's will be used or distributed to others in order to keep California's public hospital whole.

Table 3 displays where other public funds could be used to draw down the federal match. These other public funds have to be funds that are not being used to match existing Medi-Cal federal funds.

Table 3—"Other" State and County Programs Available

Description of Component	Amount Available for Match	Subcommittee Staff Comment
State and County Funds for CA Children'' Services (CCS) Program & Genetically Handicapped Persons Program (CHGGP)	$150 million	These are funds that are used for services that are not Medi-Cal related.
Increase rates for private and other public hospitals (PEACHs and Districts)	$134 million	Requires $134 million in state General Fund support. This dollar figure is the maximum amount of federal spending room available for these hospitals at present.
State Funds for Clinics	$45 million	This includes state funds for the Expanded Access to Primary Care Clinics, rural clinics and American Indian clinics.
AIDS Drug Assistance Program (ADAP) state-only portion of existing funding	$91 million	This is the state General Fund portion for this program currently.
County indigent care programs, including county clinics	$500 million	
Total "Other" Funds to Use to Draw Federal Match under Waiver	**$920 million**	Administration wants to show that if needed, other sources of funds can be counted to draw down the federal match

Summary of California's Existing System: Federal Medicaid financing, presently provided through the state's Disproportionate Share Hospital Program (SB 855 funds), the Emergency Services and Supplemental Payments Program (SB 1255 funds), Graduate Medical Teaching Program, and the Capital Project Debt Reimbursement Program, is an essential ingredient to California's overall health care system. Without these supplemental federal funds, California's hospital system would indeed collapse. California currently receives just over $2 billion for these supplemental federal funds as shown below:

(1) $1.033 billion Disproportionate Share Hospitals;
(2) $806 million for the Emergency Services and Supplemental Payments Program;
(3) $66.2 million for Graduate Medical Teaching Program; and
(4) $97.4 million for the Capital Project Debt Reimbursement Program.

Presently these supplemental federal fund programs operate through the use of "Intergovernmental Transfers" (IGT) and the state's existing Selective Provider Contract Waiver. Under the IGT process, governmental entities which operate hospitals—counties, the UC system, and hospital districts—transfer a specified amount of funds to the state by means of intergovernmental transfers. The state places these transfers into a special fund and then obtains federal matching funds. No General Fund support is provided for this purpose.

Necessary Next Steps for the State: As noted, California's existing Waiver expires as of June 30, 2005 unless the federal CMS grants California anther extension (we are presently operating on a six-month extension). Though discussions continue, the Administration has not been able to achieve closure on the level of federal financing to be available. As such, the Administration has clearly stated that any new federal Waiver agreement must be done through the policy committee process due to the unknown timing of closure on the proposal, as well as the need to craft many complex details which will take time.

State statutory changes will be needed, along with the actual crafting and approval of the complete federal Waiver package. Any legislation will require a 2/3rds vote of the Legislature. The Administration would not have the ability to do new payments for DSH, supplemental federal funding (i.e., SB 1255) or the Graduate Medical Education Program until legislation was in effect. As such, the end of Session (September 9, 2005) is the latest date for enactment.

Distribution of the funds to both the public and private hospitals will of course be key to the crafting of the legislation. The Administration has stated that they are working on criteria but have yet to share any drafts on this.

It should also be noted that the federal Office of Management and Budget maybe weighting in on the discussions as well. If issues with the federal CMS cannot be resolved soon, California may be at-risk of losing certain baseline federal funding that is presently available under our existing Waiver. **This federal funding loss could be at least $368 million.**

Questions:

1. DHS, Please provide an update as to the key components of the Administration's proposed federal Waiver. Any news on the potential timing of the Waiver agreement with the federal government?
2. DHS, Is any of portion of our baseline program at-risk, such as our transition period on the Upper Payment Limit, or any other aspect?
3. DHS, Please explain how the "limited" IGT's would work.
4. DHS, How may safety net hospitals be held harmless from a loss in federal funds?
5. DHS, When will more comprehensive data be available regarding the CPE's?
6. DHS, What discussions with the DSH Taskforce (public and private hospital coalition) are planned?

4. DHS Staff for Oversight of Existing SB 1732 Hospital Construction Program and Disproportionate Share Hospital Program (SB 855)

Issue: The DHS is requesting an increase of $387,000 ($99,000 General Fund, $95,000 reimbursements from public hospitals via the Medi-Cal Inpatient Payment Adjustment Fund, and $193,000 federal funds) to (1) extend two limited-term positions for eighteen months (from July 1, 2005 to December 31, 2007), *and* (2) hire two new permanent positions.

The DHS states that the two *existing* limited-term positions (a Research Program Analyst II and a Research Specialist I) would need to be extended to provide assistance to the existing DSH Hospital Program (i.e., SB 855) to (1) conduct research, (2) develop methodology and data sources, (3) write programming changes, (4) prepare State Plan Amendments, and (5) coordinate with the DSH Hospital Taskforce.

The DHS contends that the requested two *new* positions (an Associate Accounting Analyst and a Health Program Auditor III) would be needed to provide assistance in the existing Hospital Construction Program (SB 1732) to (1) calculate reimbursements related to bond debt service, (2) allow for timely and accurate payments of debt service requests, and (3) allow for in-depth reviews of eligible bond and project costs.

Background on SB 1732, Statutes of 1988—Hospital Construction Program: Under this program, certain hospitals are eligible to receive Medi-Cal federal funds for the reimbursement of general obligation bond debt for principal and interest costs incurred in the construction renovation and replacement of qualifying hospital facilities. For 2005-06 the budget reflects expenditures of $194.8 million ($97.4 million General Fund and $97.4 million federal funds).

Background on Disproportionate Share Hospital Program: The DSH Program is a special supplemental federal fund program aimed at making up the funding shortfall for safety-net hospitals that serve a disproportionate share of California's low-income, under-insured and medically indigent populations. As discussed above, this program is slated to be changed under the Hospital Financing Waiver.

Subcommittee Staff Comment and Recommendation: It is recommended to approve these requested positions due to workload.

Questions:

1. DHS, Please describe the budget request and need for the positions.

5. DHS Staff Proposed for Hospital Financing Waiver Purposes

Issue: The DHS is requesting an increase of $1.5 million ($686,000 General Fund and $804,000 federal funds) to **(1)** support 12 new positions, and **(2)** provide $270,000 for contract expenditures to make system changes.

Specifically, the proposal requests the following positions:

DHS Positions = 10 (9 permanent, 1 two-year limited-term)

- *Two* Staff Counsels (two-year limited-term)
- *Two* Research Analyst II's
- Research Specialist
- *1.5* Research Specialist II's
- Health Program Auditor III
- *Two* Research Specialist II's (two-year limited-term)
- Half-time Associate Governmental Program Analyst

CMAC Positions = 2 (permanent)

- Research Associate II
- Senior Hospital Negotiator

The DHS and CMAC state that these positions will be needed to address the following workload:

- Developmental of Waiver protocols and systems;
- Development of a revised methodology for the distribution of supplemental payments, DSH payments and other certified public expenditure (CPE) payments;
- Creation of new formulas and the design of internal data management systems to monitor the redistribution of supplemental payments, DSH payments and other CPE payments;
- Development and maintenance of data bases used to set interim per diem rates under the new system;
- Calculation of applicable Upper Payment Limits;
- Incorporation of hospital finance restructuring costs into the Medi-Cal estimate on an on-going basis;
- Renegotiation of current hospital contracts to implement new contract language;
- Implementation of the overall Waiver;
- Administration, monitoring and oversight of the overall Waiver;
- Development of new training materials to facilitate the new reimbursement methodology;
- Conduct expanded data analyses and modeling required to support creative approaches to difficult hospital contract negotiations;
- Process anticipated legal issues and lawsuits commencing from implementation of the Waiver; and
- Evaluation of the overall impact of the Waiver on the UC hospital system, hospitals under the Medi-Cal Program, affected counties and Medi-Cal recipients.

The DHS is also requesting a one-time only augmentation of $270,000 (total funds) to make changes to its existing "re-verification" processing for federal compliance and reporting on DSH payments made to hospitals. The DHS states that they will require two contractors for at least one-year to complete any system changes.

Legislative Analyst's Office Comment and Recommendation: In her Analysis, the LAO recommends to approve a total of five positions (one permanent and four limited-term). The LAO notes that due to the proposed restructuring, workload for some of the requested positions would replace existing tasks rather than be new workload.

Other requested positions would likely be needed only in transition to a new system.

Therefore, the LAO recommends the following actions to save a total of $992,000 ($437,000 General Fund):

- Establish one permanent Health Program Auditor III to handle the "certified public expenditure" (CPE) work;
- Establish one Staff Counsel III (two-year limited-term);
- Establish three Research Analyst II positions (two-year limited-term); and
- Delete the $270,000 ($68,000 General Fund) for one-time request for information technology contract because the LAO believes the DHS has sufficient resources for this purpose.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO regarding the number of positions at this time, but would recommend providing the $270,000 ($68,000 General Fund) for the one-time request for the information technology contract. According to the DHS, the information technology funds would be used to do system changes to re-calculate the disproportionate share hospital formulas for public hospitals once the pending Waiver is approved.

It is recommended to provide some positions to the DHS now so that hiring can commence as soon as feasible even though the Waiver is still pending.

It should be noted that any new hospital Waiver will require state statutory change and a 2/3rds vote. As such, if needed, additional resources can be provided to the DHS and CMAC at that time, when a clearer vision may be available to better discern workload needs.

Questions:

1. DHS, Please explain the budget proposal.
2. DHS, Will the filing of these positions be a priority for the DHS? If so, how will the hiring of these positions be expedited?

6. Medi-Cal Managed Care –ISSUES "A" to "C"

Background—Summary of the Administration's Proposed Managed Care Expansion:
The Administration's Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007. The Administration's proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

It is anticipated that 816,000 *additional* Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion.

Of these proposed new enrollees, **554,000 would be aged, blind or disabled**. There are about 280,000 aged, blind or disabled individuals presently enrolled in the existing Medi-Cal Managed Care Program. As such, the 554,000 represents an increase of about 100 percent.

The proposed expansion assumes the following **key components**:

- ***Expansion to 13 New Counties:*** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

  The Administration assumes the following Managed Care model configurations for these new counties:

  - Include El Dorado and Placer counties in the existing Sacramento GMC;
  - Include Imperial County in the existing San Diego GMC;
  - Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
  - Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

  The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

- ***Aged, Blind and Disabled Individuals (Mandatory Enrollment):*** The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09.

The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

- ***Acute and Long-Term Care Integration (ALTCI) Proposal:*** Under this proposal, health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as mental health services, social services, personal care services provided under IHSS, nursing facility services, and others). The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans ("Medicare Advantage plans), and must include Medicare prescription drug coverage.

  This proposal was discussed at length in the Subcommittee's April 4th hearing. At this point in time the Subcommittee is waiting for a response from the Administration regarding their perspective on potential modifications, such as creating a pilot project and other factors.

ISSUE "A"—Administration's Proposed Trailer Bill *(See Hand Out)*

Issue: The Administration has proposed trailer bill language for implementation of their expansion for Medi-Cal Managed Care (See Hand Out).

The Administration's proposed language does the following (Section 20, page 24):

- *Section 14094.4 (a):* This section provides the Director of Health Services the authority to expand Medi-Cal Managed Care subject to appropriation.
- *Section 14094.4 (b):* This section broadly defines the terms "managed care plan contracts" and "managed care health plan" to also mean acute and long-term care integration plans. It also defines "seniors and persons with disabilities".
- *Section 14094.4 (c):* This section provides complete authority for the Director of Health Services to expand Medi-Cal Managed Care and enter into exclusive contracts (i.e., bid or non-bid basis, and exclusive or non-exclusive basis) on a statewide or more limited geographic basis.

  It requires the mandatory enrollment of aged, blind and disabled individuals.

  It enables the Director of Health Services to convert *any* geographic service area within the state from one Medi-Cal service model (such as Geographic Managed Care

or Two Plan Model) to another Medi-Cal service model (potentially including any new model that may be developed as well).

It enables the Director of Health Services to develop or procure (through bid or non-bid basis, and exclusive or non-exclusive basis) a uniform assessment protocol and data set for individuals with chronic care needs that may be required be used by some or all of the Medi-Cal Managed Care plans as designated by the Director of Health Services.

- *Section 14094.4 (d):* This section provides carte blanche authority to the DHS to implement, interpret, or make specific this article, and any applicable federal waivers by means of all county letters, all plan letters, plan or provider bulletins, or similar instructions. Thereafter, the department *may* adopt regulations.
- *Section 14094.4 (e):* This section exempts all Medi-Cal Managed Care contracts, including amendments, or change orders to existing Medi-Cal Managed Care plan contracts, from the Public Contract Code, the State Administrative Manual Management Memo 03-10, and Government Code requirements.
- *Section 14094.4 (f).* Directs the DHS to submit any State Plan Amendment or federal waiver as necessary to carry out the provisions of this article. Directs that the article shall be implemented only to the extent that federal funds are available.
- *Section 14094.4 (g):* Clarifies that this article will not in any way limit CMAC's authority.
- *Section 14094.4 (h):* Exempts any amendments or change orders to the External Quality Review Organization (EQRO) contract from the Public Contract Code and the State Administrative Manual Management Memo.

Background—Existing State Statute on Medi-Cal Managed Care: Existing state statute enables the Director of the DHS to expand the Medi-Cal Managed Care Program to include the mandatory enrollment of **families and children** in additional counties or services areas. However, for the existing Geographic Managed Care counties (i.e., Sacramento and San Diego), any expansion of these two areas would require amending that section of state law dealing specifically with their operation of that model.

Any conversion of the aged, blind or disabled populations from voluntary to mandatory enrollment status would require state statutory change. In addition, a federal Waiver (or Waivers) would also be needed for this purpose.

It should be noted that the original implementing legislation for Medi-Cal Managed Care was Senate Bill 485, Statutes of 1992. SB 485 was the Omnibus Health Trailer Bill to the Budget Act of 1992. These were very difficult fiscal times and broad authority was provided to the DHS to commence with a Managed Care Program for children and families.

Through-out most of the 1990's, the Medi-Cal Managed Care Program struggled with various Medi-Cal enrollment issues, complex contract issues, rate development, lawsuits, and problems with the federal CMS. In fact, the federal CMS required California to halt enrollment for a period of time until certain measures could be put into place.

Subcommittee Staff Comment and Recommendation: In discussion with DHS staff it was said that the DHS has broad authority now to operate the program and the trailer bill language generally codifies their existing authority.

However in the view of Subcommittee staff, there are significant concerns with the DHS trailer bill language. First, this broad authority they are seeking pertains to aged, blind and disabled individuals. These are the most medically needy individuals that the state serves, including individuals with severe mental illness, individuals with developmental disabilities, children with special needs, and frail seniors with dementia. Under the DHS language, the Legislature would have minimal oversight responsibilities regarding the entire Medi-Cal Managed Care Program, other than appropriation responsibilities. All programmatic changes, contracts, policies and administration would be at the sole discretion of the Director of Health Services and administrative decisions as directed by the federal CMS.

Second, the proposed language contains no provisions regarding (1) quality of care standards, (2) performance measures, (3) continuity of care issues and related transition issues, (4) program evaluation components, (5) rate design, (6) obtaining more comprehensive encounter data from plans, as well as other related factors. The DHS has missed an opportunity here to improve the **core** Medi-Cal Managed Care Program. A strong core program would offer a better opportunity from which to expand into additional geographic regions and to more medically needy populations.

Third, extensive stakeholder meetings were convened last year by the Administration to garner perspectives and suggestions from constituency groups about how to improve the Medi-Cal Program, including managed care. However, the proposed trailer bill language does not address or contain any of these items, including those proposed by managed care plans.

Fourth, in her 2004-05 Perspectives and Issues publication, the LAO discussed the need for various program improvements within the Medi-Cal Managed Care Program. However, none of these suggestions have been incorporated into the proposed language.

Questions:

1. DHS, Please walk through each of the component pieces of the proposed trailer bill legislation.
2. DHS, Has any thought been given to adding other components to this language submittal?

ISSUE "B"—Administration's Request for Staff & Contract Funds

Issue: The DHS is requesting a total increase of $7.6 million ($3.3 million General Fund and $4.3 million federal funds) to **(1)** hire 47.5 new state staff as of July 1, 2005, **(2)** provide $1 million for external contracts, and **(3)** provide $1.9 million for "interdepartmental" contracts.

This proposal also assumes the need for additional resources to be obtained in 2006-07.

The table below provides a summary of where the 47.5 requested positions would be located and also displays the 2006-07 anticipated future request for next year. This proposed staffing level by the Administration assumes legislative approval of their entire managed care proposal—13 new counties, mandatory enrollment in all counties of aged, blind and disabled individuals, and implementation of the Alternative Long-Term Care Integration Program.

Table 1: **Summary of Administration's Staffing Proposal**

DHS Divisions & CMAC	New Positions for 2005-06 **(Budget Year)**	New Positions for 2006-07 **(Next Year)**	Total Positions
Medi-Cal Managed Care	22.0	14	36
Payment Systems	8.5	0	8.5
Long-Term Care	8.0	0	8
Administration	5.0	3.0	8
Legal Services	4.0	0	4
CA Medical Assist. Commission	0	3	3
Totals	**47.5 Requested**	20.0 Future	67.5

The following discussion outlines the position request by each area.

Medi-Cal Managed Care Division (22 positions, or 40 percent of the budget request):
The DHS states that existing staffing levels have been significantly depleted over the last 18 months to 24 months as a result of the budget deficit, resulting positions cuts, and the extended hiring freeze instituted by the Governor, which has resulted in about a 30 percent reduction of staff within the DHS Medi-Cal Managed Care Division. As such, they are requesting 22 new positions.

Table 2—Medi-Cal Managed Care Division Request *(22.0 positions)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	Coordinate activities for the expansion	1.0
Staff Services Manager I	Oversee contract development and operational issues	2.0
Associate Gov Prog Analysts	Provide additional contract management for new contracts in the expansion counties.	8.0
Associate Mgmnt Auditor	Conduct ongoing financial monitoring of contracted health plans in the new counties and work with actuary staff in development of experienced-based rates for both the expansion areas *and* aged/blind/disabled	2.0
Office Technician	Perform duties due to expansion	1.0
Nurse Consultant III	Develop new policies and procedures relative to clinical standards, policies, and quality measures for quality of care	1.0
Medical Consultant II	Support special needs services	1.0
Nurse Evaluator II	Develop medical monitoring protocols and tools for expansion population.	2.0
Research Program Spec II	Support rate methodology and encounter data research	1.0
Research Program Spec I	Support rate methodology and encounter data research	1.0
Actuary Positions	Make actuarial valuations and verify capitation rates	2.0
Total for the Division		**22.0**

Payment Systems (8.5 positions):

Table 3—DHS Payment Systems Division *(Two Areas)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
A. Health Care Options	Conduct materials development, system modification and contract amendments with Health Care options contractor (Maximus)	**6.0 total**
Staff Info Systms Analyst		2.0
Associate Gov Prog Analysts		2.0
Research Program Specialist I		1.0
Office Technician		1.0
B. Fiscal Intermediary & Provider Relations	Oversee written communications, training materials and serve as DHS resource for provider activities (billing questions and claims processing)	**2.5 total**
Office Technician		0.5
Total for the Division		**8.5 total**

Long-Term Care (8 positions):

Table 4—DHS Long-Term Care Division

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	To coordinate and provide liaison with other programs and state departments.	1.0
Staff Services Manager I	To supervise 6 staff and to develop ALTCI policies.	1.0
Associate Gov Prog Analysts	To provide ALTCI policy development and oversight.	4.0
Nurse Evaluator II	To provide review and evaluation of current clinical outcome measures and clinical practice guidelines.	1.0
Office Technician	To provide administrative support	1.0
Total for the Division		**8.0**

Administration Division (5 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Personnel Specialist	Process workload with the requested positions	0.5
Associate Gov Prog Analyst	Perform contract management	1.0
Research Program Specialist II	Develop and maintain complex data projects for the Fiscal Forecasting Branch	1.5
Account Technician	Process additional workload	1.0
Office Assistant	Support to the contract processing activities	1.0

Legal Services (4 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Counsel III	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Counsel I	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Services Manager I	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0
Associate Gov Prog Analyst	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0

Contract Funding Request: The DHS is also seeking about $3 million (total funds) in additional contract funds for 2005-06. These contract funds would be used as follows:

- Health Care Options Contract ($300,000 for 2005-06): Maximus is the Medi-Cal Managed Care "enrollment broker" who (1) presents the plan choices to the pending managed care enrollee, and (2) defaults enrollees to plans as needed if a choice is not made. The DHS states that costs are calculated based on enrollment. The projected costs for 2005-06 are $300,000 (total funds) for them to (1) develop new enrollment materials, (2) revise existing enrollment materials, and (3) begin system change work for the development of new informing materials specific to the aged, blind and disabled populations. Expenditures for the out-years would increase.

- *Fiscal Intermediary (Electronic Data Systems Contract) (total funds not specified by the DHS):* The DHS states that changes would need to be made to the "adjudicated claim line" process as well as other aspects.

- *External Quality Review Organization ($312,000 total funds):* The EQRO is an accrediting body that is an expert in the scientific review of the quality of health care provided to Medi-Cal enrollees in a state's managed care program. It activities are required by federal law. It is unclear however what specifically would be done with these funds.

- *Translation Services—University of California System ($190,000 total funds):* The DHS presently has a consultant services contract with the UC to translate written Medi-Cal Managed Care informing materials for Medi-Cal enrollees. This would include expenditures for both the proposed geographic expansion as well as the proposed mandatory enrollment of aged, blind and disabled.

- *Independent Assessment of Waivers ($210,000 total funds):* These funds would be needed only if the Legislature grants the DHS authority to seek a federal Waiver for the mandatory enrollment of aged, blind and disabled individuals. Further, it is unclear as to why funds would be needed in 2005-06 when the DHS assertive schedule shows that enrollment would not commence until at least January 1, 2007.

- *Information Technology Contract ($1.215 million total funds):* This proposed expenditure of $1.215 million ($304,000 General Fund) would be for "systems changes" to (1) develop of programming specifications, (2) coordination of the Health Care Options vendor (Maximus), (3) development of materials for training new counties about the Medi-Cal Eligibility Determination System related data, (4) development of changes to plan tables, (5) assessment of HIPAA related changes, (6) assessment of changes to paid claims data, (7) coding of system changes, (8) testing of system changes, and (9) coordination of external testing with counties.

- *Outreach to Aged, Blind and Disabled ($500,000 total funds):* The DHS states that these funds are needed if mandatory enrollment of aged, blind and disabled individuals is done.

- *Long-Term Care Diversion Assessment Tool ($500,000 total funds):* It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction. This contract is part of the proposed Acute Long-Term Care Integration Program.

Legislative Analyst Office Comment and Recommendation: The LAO notes that once the Legislature has decided what aspects of the Administration's proposed Medi-Cal Managed Care proposal it wants to proceed with, then it can decide what necessary DHS staff components and contract amounts are necessary. For example, if the Legislature wants to proceed with expansion of the existing Managed Care Program (i.e., children and families, and voluntary enrollment of aged, blind and disabled) into new geographic areas, then less DHS resources would be necessary in 2005-06.

However, at a minimum, the LAO would recommend deleting at least 5.5 of the requested DHS 47.5 positions for savings of $469,000 (General Fund), and to make four of the positions two-year limited-term appointments.

Subcommittee Staff Comment and Recommendation: Clearly many issues remain regarding the Administration's proposal. The Subcommittee was only provided with a timeline that contains objectives on Friday, April 29th, just prior to completion of this agenda even though this information was requested over seven-weeks ago. It is recommended to hold the appropriation of resources open until the Subcommittee has received additional requested information and has decided what aspects of the Administration's proposal is to be acted upon through the budget process.

Questions:

1. DHS, Please provide an overview of the budget request.
2. DHS, Please provide a summary of the major milestones and objectives of what would need to be completed when under your proposal.

ISSUE "C"—Managed Care Rate Structure *(Informational)*

Issue: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute" process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Questions:

1. DHS, Please provide an overview of the existing rate determination process for Medi-Cal Managed Care.
2. DHS, Please provide an overview of the work products to be produced by Mercer.
3. DHS, How may this new information be used to develop a revised rate methodology?

7. DHS Staff for Restructuring ICF-DD Rates

Issue: The Subcommittee is in receipt of a Finance Letter that requests an increase of $145,000 ($72,000 General Fund) to support 1.5 new Associate Governmental Program Analyst positions. These positions would be effective as of September 1, 2005 and are intended to be permanent.

The purpose of these positions would be to work on a State Plan Amendment to include Day Programs and associated non-medical transportation in the per diem rate paid to Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).

Specifically, federal regulations allow a state to create a broader definition of ICF-DD services than those presently used by the DHS, including Day Program services and non-medical transportation. If a broader ICF-DD service definition is used, the state could save tens of millions in General Fund support (due to the receipt of federal funds).

Under the state's existing system, Day Program services for individuals with developmental disabilities are funded through the Department of Developmental Services and purchased by the non-profit Regional Centers. Presently, about 50 percent of expenditures for these Day Program services are funded using 100 percent General Fund support. If Day Program services were reimbursed under a more inclusive ICF-DD rate, a federal match could be received for most of this General Fund expenditure.

The existing DHS cost methodology for ICF-DD facilities is presently defined in California's state Medi-Cal Plan. Therefore, any change to this rate would require a "State Plan Amendment" (SPA) and federal CMS approval.

It should be noted that other states have been successful in covering additional services and supports (i.e., broader definition of ICF-DD services) as noted.

It is not anticipated that any General Fund savings will be available from the restructuring until at least 2006-07.

Prior Subcommittee Hearing—February 23rd: In this hearing, the Subcommittee discussed a January 2003 report (PNP associates), funded by the Department of Developmental Services, that identified the potential for the state to save tens of millions in General Fund if the DHS were to re-structured how it reimburses ICF-DD facilities in the manner identified in the Finance Letter. The LAO also recommended this approach in the Subcommittee hearing.

Additional Background--What Are Intermediate Care-DD Facilities? Generally, ICF-DD facilities are facilities that provide 24-hour assistance, including nursing care, habilitation services, active treatment, and supervision in a structured setting. This type of licensed facility includes the state Developmental Centers, as well as smaller six-bed facilities in various regions of the state.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the positions but to make them two-year limited-term, and not permanent. The activities of these positions do not require permanent positions.

Questions:

1. DHS, Please provide a brief summary of the proposal.

8. Implementation of the Medicare Modernization Act (MAA)—Affect on California Due to Federal Changes *(See Hand Outs)*

Issue: The MAA makes significant changes to the federal Medicare Program and as such, affects the state's Medicaid (Medi-Cal) Program.

Part D of the MAA is the new outpatient prescription drug benefit that will be implemented as of January 1, 2006. As of this date, Medicare will begin to pay for outpatient prescription drugs through "Prescription Drug Plans (PDPs) or Medicare Advantage plans. Enrollment into these plans will include "dual eligibles"—individuals enrolled in both Medi-Cal and Medicare.

There are about 1 million Medi-Cal/Medicare enrollees (dual eligibles) in California. According to the DHS, about 137,000 of these individuals are enrolled in Medi-Cal Managed Care and 937,000 are enrolled in "fee-for-service" Medi-Cal. Dual eligibles tend to be in poor health due to chronic illnesses and conditions.

According to the DHS and LAO, the scope of this federal legislation is so broad that it may be years before all of its initiatives are fully implemented and its overall ramifications are completely understood.

As noted in Table 1 below, the Governor's budget assumes savings of $100 million (General Fund) in 2005-06.

However beginning in 2006-07, this "savings" is estimated to be reduced to only $17 million and by 2008-09, the state will have increased General Fund expenditures by about $758 million (General Fund) as shown in Table 2. The significant cost increases result due to the "clawback", as well as a loss of drug rebate revenues.

Table 1: Summary of Governor's Budget Due to Part D for Medi-Cal

Description of Component	**2005-06 (Half Year) (General Fund)**
Reduced Drug Costs: Assumes elimination of dual eligible drug benefits beginning January 1, 2006 with only continuation of barbiturates, weight loss/gain, and benzodiazephines. This assumes that dual eligibles are about 55.2 percent of the Medi-Cal pharmacy expenditures.	**-**$747 million
"Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles.	$646 million
Proposed Net Impact for Budget Year	**Savings of $101 million**

Table 2-Potential Impact in Future Years

Component	**2006-07 (General Fund)**	**2007-08 (General Fund**	**2008-09 (General Fund)**
Reduced Drug Costs	$1.617 billion	-$1.818 billion	-$2.043 billion
"Clawback"	$1.428 billion	$1.574 billion	$1.737 billion
Reduced Drug Rebates	$273 million	620 million	$705 million
Estimated Annual Cost	**$84 million**	**$376 million**	**$399 million**
Estimated Cumulative	**-$17 million**	**$359 million**	**$758 million**

The California Health and Human Services Agency (CHHS Agency) has established a Taskforce made up of representatives from all of the applicable health and human services departments, including the DHS, Department of Aging (where HICAP is funded), Department of Developmental Services, Department of Mental Health and others. According the CHHS Agency, this Taskforce group has been meeting and discussing system-wide issues.

With respect to fiscal issues regarding the DHS responsibilities, the key issues include the following:

- Working with the federal CMS on the "clawback" provisions and what that means specifically for California. (This is the federal law that requires states to make a "state contribution" payment to help finance Part D dual eligibles.)

- Transition and wrap-around coverage for dual eligibles who would no longer be able to obtain their drugs from the Medi-Cal Program as they presently do and who will need to enroll in a Prescription Drug Plan (PDP) or Medicare Advantage plan as part of the federal Part D-sponsored benefit. The Governor's budget assumes no transition or wrap-around coverage for these individuals.

  As such, the Governor is proposing trailer bill legislation to eliminate the provision of drug benefits under the Medi-Cal Program to those who are dually eligible (Medi-Cal and Medicare), *except* as approved by the Department of Finance.

- Informing dual eligibles about the program and facilitating their enrollment into a PDP or Medicare Advantage Plan.

- Re-calculating drug rebates that are presently collected under the Medi-Cal Program. It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions.

Subcommittee Staff Comment and Recommendation: The May Revision is anticipated to contain several adjustments to the Governor's budget due to updated discussions with the federal CMS regarding implementation of the Part D Program. As such, it is recommended to leave this issue "open".

Questions:

1. LAO, Please provide a brief summary of the key aspects to the new Medicare Part D drug coverage program.
2. DHS, Please discuss the "clawback" provision and the new information you have received from the federal CMS.
3. DHS, Please provide an update on the key fiscal aspects identified above.